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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2011-546*

13 **NATOSHA ROCHELLE BOND**
14 **1120 Edgewood Avenue**
Brownsville, TN 38012
Registered Nurse License No. 681303

ACCUSATION

15 Respondent.

16
17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
20 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department
21 of Consumer Affairs.

22 2. On or about June 22, 2006, the Board of Registered Nursing issued Registered Nurse
23 License Number 681303 to Natosha Rochelle Bond ("Respondent"). The Registered Nurse
24 License was in full force and effect at all times relevant to the charges brought herein and will
25 expire on March 31, 2012, unless renewed.

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1 8. California Code of Regulations, title 16, section 1443, states:

2 "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the
3 failure to exercise that degree of learning, skill, care and experience ordinarily possessed and
4 exercised by a competent registered nurse as described in Section 1443.5."

5 9. California Code of Regulations, title 16, section 1443.5 states:

6 "A registered nurse shall be considered to be competent when he/she consistently
7 demonstrates the ability to transfer scientific knowledge from social, biological and physical
8 sciences in applying the nursing process, as follows:

9 "(1) Formulates a nursing diagnosis through observation of the client's physical condition
10 and behavior, and through interpretation of information obtained from the client and others,
11 including the health team.

12 "(2) Formulates a care plan, in collaboration with the client, which ensures that direct and
13 indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and
14 for disease prevention and restorative measures.

15 "(3) Performs skills essential to the kind of nursing action to be taken, explains the health
16 treatment to the client and family and teaches the client and family how to care for the client's
17 health needs.

18
19 "(5) Evaluates the effectiveness of the care plan through observation of the client's physical
20 condition and behavior, signs and symptoms of illness, and reactions to treatment and through
21 communication with the client and health team members, and modifies the plan as needed.

22 "(6) Acts as the client's advocate, as circumstances require, by initiating action to improve
23 health care or to change decisions or activities which are against the interests or wishes of the
24 client, and by giving the client the opportunity to make informed decisions about health care
25 before it is provided."

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STATEMENT OF FACTS

13. At all relevant times, Respondent was employed as a Registered Nurse at Kaiser Permanente Hospital ("Kaiser") in Oakland, California.

14. On January 25, 2009, Patient A, an anorectic 90 year-old male was admitted to Kaiser for dehydration, altered mental status and in early kidney failure. His physician ordered that Patient A receive a multivitamin and Tylenol if needed for mild pain.

15. Respondent assumed care for Patient A on January 26, 2009. Her responsibilities included checking to ensure that the computer printout of medications to be administered to Patient A, known as a Medication Administration Record ("MAR"), matched the medications as ordered by his physician. Respondent verified, by placing her initials on the MAR, that she had confirmed that the medications listed on Patient A's MAR matched the medications as ordered by his physician.

16. At approximately 9:44 a.m., Respondent administered two anti-hypertensive medications to Patient A: Lisinopril 40 milligrams and Amlodipine 10 milligrams. She also administered an intravenous medication for gastric ulcers (Pantoprazole 40 milligrams) and an electrolyte replacement, Potassium Chloride. None of these medications had been prescribed by Patient A's physician.

17. During her shift, Respondent noted that Patient A's total intake (by mouth and intravenous fluids) was 1120 milliliters, while his urinary output was only 400 milliliters. Respondent did not advise Patient A's physician of the discrepancy between his intake and output.

18. Respondent also noted that from noon to the end of her shift at 4:00 p.m., that Patient A was "sleeping."

19. At 9:05 p.m., Patient A was found to be hypotensive with a respiratory rate of 2 to 6 breaths per minute. Patient A was transferred to the Intensive Care Unit. He never recovered consciousness and on January 30, 2009, was determined to be brain dead. All life support was then discontinued.

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1 FIRST CAUSE FOR DISCIPLINE

2 (Gross Negligence/Incompetence – Medication Error)

3 20. Respondent is subject to disciplinary action for gross negligence and/or incompetence
4 under Code section 2761, subdivision (a)(1), in that her failure to reconcile the MAR with the
5 physician orders for Patient A, resulted in Patient A being administered medications that were not
6 order by his physician. Such conduct constitutes an extreme departure from the standard of
7 nursing care, and/or was not the practice of a competent nurse as set forth above in paragraphs 13
8 through 19.

9 SECOND CAUSE FOR DISCIPLINE

10 (Unprofessional Conduct – False Entry)

11 21. Respondent is subject to disciplinary act for unprofessional conduct pursuant to Code
12 Section 2761, subdivision (a)(1), as defined in Section 2762, subdivision (e), in that she falsely
13 verified on Patient A's MAR that all medications listed on this form matched the medications
14 ordered by Patient A's physician, when in fact this verification never took place. The facts in
15 support of this cause for discipline are set forth above in paragraphs 13 through 19.

16 THIRD CAUSE FOR DISCIPLINE

17 (Incompetence – Failure to Monitor Patient)

18 22. Respondent is subject to disciplinary action for incompetence under Code section
19 2761, subdivision (a)(1), as defined in the California Code of Regulations, title 16, section
20 1443.5, in that she failed to formulate a nursing diagnosis through the observation of the changed
21 arousal status of Patient A and failed to formulate a plan of care in response. Said omissions were
22 not the practice of a competent nurse and led to the injury of Patient A as set forth above in
23 paragraphs 13 through 19.

24 FOURTH CAUSE FOR DISCIPLINE

25 (~~Incompetence – Failure to Advise Physician of Diminished Output~~)

26 23. Respondent is subject to disciplinary action for incompetence under Code section
27 2761, subdivision (a)(1), as defined in the California Code of Regulations, title 16, section
28 1443.5, in that she failed to advise Patient A's physician of his diminished urinary output, an

omission that was not the practice of a competent nurse as set forth in paragraphs as set forth in
above in paragraphs 13 through 19.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
and that following the hearing, the Board of Registered Nursing issue a decision:

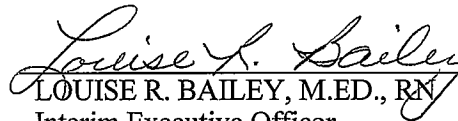
1. Revoking or suspending Registered Nurse License Number 681303, issued to
Natosha Rochelle Bond.

2. Ordering Natosha Rochelle Bond to pay the Board of Registered Nursing the
reasonable costs of the investigation and enforcement of this case, pursuant to Business and
Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: _____

12/16/10


LOUISE R. BAILEY, M.ED., RN

Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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